

MEDICAL RECORD	RELEASE FROM RESPONSIBILITY FOR DISCHARGE
NATIONAL INSTITUTES OF HEALTH, THE CLINICAL CENTER	DATE

I hereby request my discharge from this hospital against the advice of its medical staff. It has been explained to me that my present condition is such as to require further hospitalization and that I leave the hospital at my own risk. I hereby release the hospital and its staff from all responsibility for any consequences of this act.

SIGNATURE OF PATIENT

IF PATIENT IS A MINOR OR INCOMPETENT TO SIGN:

SIGNATURE OF RESPONSIBLE GUARDIAN

RELATIONSHIP TO PATIENT

WITNESS

SIGNATURE OF WITNESS
